GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 4, 2025

Todd Dockerty
Woodland Terrace at Longmeadow
13 Longmeadow Village Dr.
Niles Township, MI 49120

RE: License #: AH110353051
Investigation #: 2025A0627003
Woodland Terrace at Longmeadow

Dear Todd Dockerty:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH110353051
Investigation #:	2025A0627003
Complaint Receipt Date:	07/18/2025
Investigation Initiation Date:	07/22/2025
Report Due Date:	09/17/2025
Licensee Name:	Dockerty Health Care Services, Inc.
Licensee Address:	8850 Red Arrow Hwy., Bridgman, MI 49106
Licensee Telephone #:	(269) 487-9468
Administrator:	Roni Brown
Authorized Representative/	Todd Dockerty
Name of Facility:	Woodland Terrace at Longmeadow
Facility Address:	13 Longmeadow Village Dr., Niles Twp, MI 49120
Facility Telephone #:	(269) 683-7900
Original Issuance Date:	01/22/2014
Status: (bold)	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	90
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility made a medication error resulting in the resident's death.	Yes
Additional Findings	No

III. METHODOLOGY

07/18/2025	Special Investigation Intake 2025A0627003
07/22/2025	Special Investigation Initiated - On Site
07/22/2025	Contact - Telephone call made Telephone interview w/ Complainant
07/22/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

The facility made a medication error resulting in the resident's death.

Investigation:

On 07/17/2025, a complaint was received alleging that on 06/29/2025, when the facility medication passer went in at 4:24 am to give Resident A her scheduled Lorazepam 0.5 mg by mouth, Resident A was mistakenly given morphine 30 mg by mouth. Resident A was discovered deceased at 8:30 am.

On 07/22/25, I interviewed the complainant by telephone. The complainant reported the facility executive director (ED) gave Resident A's family the following details of the incident on 06/29/2025. The complainant reported that on 06/29/2025 SP3 gave Resident A Morphine 30 mg instead of Lorazepam 0.5 mg at 4:23 am. The complainant reported a breathing treatment was administered at 5:11 am. The complainant reported at 7:00 am facility personnel found a discrepancy in the narcotic count. The complainant reported Resident A was discovered deceased at 8:30am.

On 07/22/2025, I interviewed Heather Cavinder, Executive Director/administrator (ED), during an onsite complaint investigation. The administrator confirmed that the incident described above happened and that the call she made to Relative A1 on 6/30/2025 informing Relative A1 of the findings was the hardest call she had ever made. The administrator stated that SP3 had discovered the discrepancy during the narcotic count at 7:00 am on 06/29/2025 but did not inform anybody of the discrepancy as is expected by the facility's policy.

The administrator reported there were expectations set out in the facility's policy titled "*Medications & Treatments"* that were not adhered to by SP3. The administrator reported SP3 did not contact the Executive Director or Medication Room Manager, receive instructions on next steps, or immediately contact the prescriber upon discovering the medication error. The administrator reported SP3 did not complete an Incident Report until 06/30/2025, more than 24 hours after the incident. The administrator reported SP3 also did not go to Resident A to assess Resident A's condition at the time the medication error was discovered on 06/29/2025. The administrator reported that narcotic counts are performed at each shift change and that two qualified persons, one from each shift, are present.

On 7/29/2025, a call to the administrator confirmed that on the morning of 6/29/2025, there were two staff persons present for the narcotic count and witnessed the narcotic count discrepancy. The administrator reported the expectation when counting narcotics that for any discrepancy discovered it is the responsibility of the off going shift to investigate the discrepancy and take appropriate steps to ensure it is rectified.

I reviewed Resident A's medication administration record (MAR) for July 2025. Review of the MAR noted that on 06/29/2025 at 4:24 am Lorazepam 0.5mg was documented as being given and at 5:11 am, a scheduled breathing (aerosol) treatment, Ipratropium/albuterol 0.5-3mg/3ml was given as ordered. Resident A was given another residents' Morphine 30 mg tablet by mouth. Resident A had a standing order for Morphine 100 mg/5ml, 0.25 ml every hour as needed for shortness of breath. Resident A had not used any of the ordered "as needed morphine."

On 07/22/2025, I interviewed SP2 at the facility. SP2 reported she was working when Resident A was discovered not breathing by resident care staff. SP2 reported she immediately notified hospice, and that hospice pronounced Resident A deceased at 10:00am. SP2 reported the family was notified by SP2 and was at the bedside within approximately 30 minutes.

I reviewed SP3 training documents. The documents included training titled *"Unusual Occurrence and Follow -Up Training"* with a passing post-test dated 03/12/2025, a "*Medication Technician Performance Checklist*" dated 07/10/2024, and a passing "*Medication Aide Knowledge Checkup*" test, dated 08/10/2023.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Staff interviews and document review of Resident A's medication administration records support the allegation that Resident A received a medication in error. Facility staff failed to provide appropriate notice and action when the medication error was discovered, including assessment of the resident for reactions. Based on these facts, the violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the status of the license

08/07/2025

Rick Brummette Date
Licensing Staff

Approved By:

09/03/2025

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section